Health Care Legislative Initiative Project
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THE CONCEPT OF LEGAL REGULATION OF PROPERTY LEASE IN HEALTH SECTOR

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INTRODUCTION

In market-driven economic environment, *leasing of tangible assets (property leasing)* of health care organizations is among the most effective forms of economic relations.

The lease has gained much popularity in Russia as a form of economic relations. It helps include temporarily spare assets into business operations at no additional public expense. Leasing of state/municipal health care organizations' assets may help improve cost-effectiveness of their operation and make the entire health care system financially sustainable.

At present, property leasing in health sector is subject to practically no legal regulation, resulting in chaotic lease patterns and the wide spread of "shadow" leasing practices.

"Shadow" property leases are practiced in the following typical forms:

- ✓ on secluded agreement of parties, a formal lease is concluded where the minimal legally allowed local rental rate is indicated. The factual payments will be then channeled on outside of the scope of governmental controls; at best, those amounts will be used to cover financial deficit (debt) of health care organization and increase labor compensation to employees, but as a rule they are privately shared by health care organization senior managers, thus giving rise to corruption in health sector;
- ✓ the lease is substituted with a joint venture agreement, which results in consequences identical to those described for the situation of understated rental rate.

Property leasing development in health sector is constricted with the lack of clear legal regulations and enacted incentives to motivate health care managers to conclude lease contracts.

The primary goal of this Concept is to define conditions helpful to bring out of "shadow" market the majority of profit-bringing business operations in health care organizations and redirect "shadow" business finances to serve needs of public health. Another goal of the Concept is to create a regulatory field that will legalize incentives for health care managers and employees to optimize utilization of capital assets of health care organizations when concluding lease contracts.

Implementation of key principles of the Concept will create additional opportunities to develop non-government and commercial health care systems that will use surplus capacities of health care facilities.

This Concept of Legal Regulation of Property Lease in Health Sector includes general provisions, principles of leasing, recommended lease types and lease forms, and principal conditions and requirements to legally regulate relations of parties to a *lease (property rental contract).*

The Concept has been developed in the framework of "Problems of Economic and Legal Regulation of Property Leasing in Health Sector" project.

Provisions of this Concept will become more clear and specific with drafting federal laws and regulations to govern property leasing in health sector.

General methodological approaches to implement the mechanism of leasing in health sector and major methods for evaluation of leased assets will be described in methodic recommendations on assets evaluation in health

sector. Besides, the Concept will serve the basis for an informational analytical report to be distributed to officials of the Ministry of Health of the Russian Federation and senior managers of state/municipal health care organizations.

1. ECONOMIC PREREQUISITES FOR INTRODUCING LEASING IN HEALTH SECTOR

The critical state of national economy, factual decrease of gross domestic product (GDP), deficiency of government budgets at all levels and non-budget public funds have resulted in shrinking public health expenditure – both on absolute and relative scales.

According to official statistics, aggregate public allocations to health sector in 1998 decreased by 9.3% as compared to the previous year, as the result of 1998 financial crisis. The rate of health expenditure decrease was the highest in government budgets at all levels – 16.5% on average as compared to the previous year, and slight increase in mandatory health insurance income could not compensate for it.

Despite extremely low rates of GDP growth in current prices, the absolute cutback of government health spending resulted in its share decrease from 4.2% of GDP in 1997 to 3.6% in 1998. Poorly coordinated efforts to attract additional financial resources would not solve the problem of deficient government financing. The clear trend of past years was the reduction of public sources' role in funding health industry and the increase of private share in the aggregate coverage of health care costs incurred within state/municipal healthcare system, which has resulted, first of all, in restricted social access to health services delivered to the population free of charge. This factor adds on to the present social tension on the national scale.

Significant cutback of government allocations to public health sector necessitated the reform of the entire system of health care financing and delivery. The major task of the reform was to find financial resources to cover the minimum of operational costs of health care organizations. The acute shortfall of government funding forced the vast majority of public health care facilities to develop commercial business lines, primarily, to offer their services on fee-for-service basis. In the absence of thoroughly developed laws and regulations, profit-generating health care enterprises will tend to practice uncontrollable delivery of health services in the most uncivilized, "shadow-business" fashion. Hard financial pressures may as well push health care organizations to other alternative ways of attracting additional financial resources.

In the transition market economy, privatization of property is among the main tools used to attract more investments. The idea of privatization of surplus capacities of health care facilities was especially popular at early stages of market-oriented reforms in the USSR and then in the Russian Federation.

However, negative consequences of privatization in the industrial sector indicated that in social sphere, and, most of all, in health sector, privatization was an option to be used with much prudence.

From early 90's, the issue of privatization of health care facilities was widely discussed by legislators, as well as in special literature and mass media with much involvement of wide public. Health care professionals, however, usually state the opinion that privatization in health sector must be banned. The explanation behind that is that, first, they pursue their corporate professional interests, for privatization may predictably lead to regular health care workers losing their jobs and high social standing, while evolving labor relations in private health care organization may acquire ugly features of "wild" capitalism. Second, health practitioners demonstrate deep and thorough understanding of negative consequences of privatization of health care facilities, including restricted availability of health services to the population in need for them.

Though the two motives may look contradictory, it is explainable in view of deep historical tradition of humane physicians' attitude to their patients. On the other hand, the most pragmatic physicians deny privatization for the reason of their sober understanding that opportunities for "shadow" income will be restricted, while profits will be generated on the most part by owners of privatized facilities. Nonetheless, the entire medical society, beginning with bottom-line healthcare workers and up to Health Ministry officials, agree that profound reforms are required in health sector to improve efficiency of health care delivery in the situation of market-regulated economy and deficient government funding.

The suggested reforms imply introduction of new economic relations without changing owners of health care facilities. At the same time, the moratorium imposed on privatization of health care facilities in early 90's is effective so far.

In the situation of developing market and the moratorium on health care facilities privatization, making utilization of available resources more effective is not an easy task. In this connection, the role of commercial enterprises with the use of property leasing of various types is enhanced.

Both legislative and executive authorities of the Russian Federation readily recognize that the problem of property leasing discussed in this Concept is pressing. However, not a single draft supposed to regulate issues of property ownership submitted to and considered by State Duma of the Russian Federation will furnish a complete system of regulations and provisions on property ownership and leasing in social sphere.

The above circumstances entail the pressing and continuous need for working on these problems on conceptual and legislative levels, as well as for drawing attention of health care leaders and professional legislators to this scope of problems.

In the area of practical health care management and finance, however, continuous efforts have been made to work out practicable approaches to overcome the contradiction between ineffective use of resources available in health sector and the ban to withdraw health care facilities from state (federal and municipal) ownership in the mode and to the extent dictated by current laws.

One way to overcome the acute contradiction between the need for optimized resource utilization and health care organizations' inability to exploit temporarily idle capacities was to develop leasing relations, and they started to evolve in late 80's through early 90's.

This form of organizational economic relations aligned financial interests of the society, health care organization, and its individual employees, which were to improve effectiveness of tangible and financial resource utilization in economic turnover. In the process of implementation of leasing schemes, health care workers were entitled to keep revenue (profit) either collectively or personally.

With the introduction of leasing, prerequisites for mixed ownership formed in health sector with prevalence of federal or municipal share.

For the first time in health sector, economic tools were activated to optimize utilization of rented property in order to fulfill state social order. The incentive offered by that model was that the difference between the price of social order indicated in the lease contract and factual costs of services provided under the order was kept by employees of health care organization leasing the facility.

Transition to leasing relations also resulted in the shift of fundholding function. In fact, the industry was undergoing partial denationalization, while, which was most important, the system of top-to-bottom management stayed intact in the entire health care system.

The lack of adequate resources to fund development of leasing in health sector precluded the entire network of health care facilities from transition to the leasing model, which made executive authorities to choose the way of liquidation of those 'oases' of financially motivated labor.

Alongside with clear economic and social effect of leasing relations in various types of health care facilities, the positive role of leasing in improving accessibility and quality of care, resolving the problem of adequate labor compensation and effective use of industrial capacities, a number of factors were revealed witnessing of ever increasing contradictions in health sector development:

- Deficiency of government budgets resulting in failure to fulfill the commitment to cover costs of health services provided under the social order;
- Incompatibility between actual individual income gained by a regular member of a health care organization leasing the facility and the level of salaries received by officials and administrators in the entire health care system;
- Leasing relations caused (irrespective of legislative prohibition to change ownership) factual multi-ownership patterns in health sector; in particular, the share of privately owned capital assets grew, as health care organizations purchased them with private money taken from the income generated.

Executive decisions of health authorities, direct administrative prohibition, followed by corresponding legislative acts resulted in immediate and complete liquidation of effective leasing health care organizations (enterprises). To some extent, however, it helped postpone the need to decide the most acute problems that had earlier given rise to this form of economic relations.

At present, leasing relations are regulated under the effective Civil Code of the Russian Federation (hereinafter, CC RF), which gives rather narrow interpretation of economic nature of leasing and restricts it to property

hire. This approach results in complete lack of economic motivation for health care organizations to consider development of leasing in any form.

Development and legalization of leasing in present economic settings requires, first of all, a legislative decision changing the recipient of rent paid for the leased property of health care facilities, because current legislation makes the property owner the only possible lessor who will keep the entire profit (rental fee) paid by the lessee.

Health care organizations do not own property. Usually, their function is operational management of facilities. Therefore, the entire revenue generated as rental for leased property shall be channeled to its owner.

Legislative practice has already created a precedent of partial solution of this problem. State Duma enacted the federal law “On 1999 Federal Budget” with Article 30 enabling administrations of health care facilities in federal ownership to keep revenue generated through leasing property of federally owned facilities, thoroughly reflect it in their budget and use those additional incomes as a supplementary source of budget resources for purposes of maintenance and development of their tangible assets in addition to federal budget allocations for maintenance.

However, this solution is of limited applicability (to federal health care organizations only) and effective time lag (one year).

The scope of relevance of the problem under discussion goes far beyond federal facilities only. In municipal health care organizations, it is extremely acute and solution is long overdue. In this connection, there is a clear necessity for development and approval of a special package of legislative acts to regulate development of property leasing in health sector.

2. SOCIAL PRIORITIES IN LEASING DEVELOPMENT AND ALLOCATION OF RENTALS

Leasing, according to the CC RF definition, is transfer of the right of possession and use or only use property in exchange for certain payment based on the lease contract.

Economic meaning of leasing is defined in the following fashion. First, it is a type of business based on renting property for payment. Second, it is an effective means of getting the needed property for its use for certain purposes.

Social nature of health care services determines main priorities in application of leasing relation to health sector.

The primary task of existing federal and municipal health care organizations is to provide the volume of care determined in state-guaranteed health programs. Therefore, only those property items may be leased, which are not used – directly or indirectly – in execution of this primary task.

When preparing lease contracts, third parties should consider introduction of new or additional services to be provided by health care organizations under non-government coverage. Final decisions on feasibility of leasing should take into account the above priorities.

Adherence to social priorities in lease arrangements should be supervised by executive authorities – health administrations of appropriate level, because they are the only who can actually evaluate the entire scope of consequences of implementing such contracts that will be suffered by a

territorial health care system taking into account prospects of social and economic development of the territory.

This control may be implemented with such a tool as state/municipal order for health services delivery to the population.

Municipal order is a comprehensive plan including health care utilization and cost targets for municipal providers funded from local government budget and mandatory health insurance premiums. Municipal order for health care delivery to the population defines the volume of services guaranteed by state and the territory (municipality, district), the volume of financial resources allocated to cover costs of guaranteed services, and requirements as for effectiveness of territorial health care system performance.

Only those resources of health care organizations, which are free from carrying out this predominant task, may be leased.

The main principle of leasing in health sector is: subject to leasing is property of health care organization which is completely or partially excluded from implementing state-guaranteed program of free health care provision to the population of the Russian Federation.

The decision to lease property must be supported with technical and economic grounds, including resource evaluation to estimate health care organization's property (equipment and realty) surplus/deficiency to implement state-guaranteed program of free health benefits, developed in compliance with health care organization's reporting policies.

Health care organizations' participation in state-guaranteed program must be based on contracting actual providers of care to deliver health services to the population free of charge in exchange for adequate public funding of that program by government health administrations and mandatory health insurance funds.

For complete implementation of state/municipal order and efficient health care organizations' performance in modern environments, health care organizations must have at their disposal appropriate clinical facilities and labor resources, while regional executive authorities must secure complete funding of state/municipal order.

In the process of municipal order development and planning health care volume and structure, along with balancing the order costs with the expected funds available, procedures should be designed to compensate probable deficit of financial resources allocated to cover costs of health services provided under municipal order.

This paper offers a number of options for recovering financial deficit with rentals.

Revenues generated with property leasing should be directed to economically support statutory activities of health care organization, i.e. to improve accessibility of free health services through proper maintenance of facilities and creating incentives for medical personnel.

Introduction of leasing in health sector, given that revenue generated with rentals stays within healthcare system, will help alleviate acute economic and financial problems of the industry through:

- ⇒ Close-up of certain inpatient facilities, in case of multiple hospitals providing analogous services within the same territory, or their transfer to non-government funding;

⇒ optimizing utilization of services provided by municipal health care organizations with the use of services of alternative providers of care of analogous clinical profile;
⇒ reproduction and increase of capital assets;
⇒ retention of labor resources of high professional level;
⇒ development of non-government segment in health sector.

Practical implementation of the above opportunities will accelerate territorial health network restructuring and release additional assets. Therefore, the basis will be created for leasing development in health care organizations.

3. GENERAL PRINCIPLES OF LEASING IN HEALTH SECTOR

As far as federal laws do not regulate property leasing in health sector by force of direct action, entities entering a lease have to restrict themselves to CC RF provisions on general principles of leasing.

Current legislation makes distinction between several types of leasing. Classification depends primarily on the subject (item) leased.

By now, just one type of leasing has evolved in health sector, in fact: namely, real estate leasing – rental of buildings and facilities.

Other types of leasing are represented in health care organizations by unique cases for the reason of underdeveloped legal and regulatory acts.

These categories include: equipment rental and leasing, and vehicle rental.

Despite the diversity of parties to and terms and conditions of leases in health sector, there is one feature in common: transfer of the right to possess and use, or only use a property item for an established fee with the contractual instrument of lease.

To make leasing legally consistent, the following three aspects require regulation:

1) procedure of property transfer from one person (lessor) to the other person (lessee) into temporary possession and use (or use only) for fee;
2) procedural requirements to business operations in the area of property lease;
3) liability for violation of lease terms and conditions, pre-court dispute settlement, and grounds for lease termination.

Since the right of ownership overrides other real rights acknowledged by the effective legislation, they are of derivative nature.

The right to lease property is based on the right of ownership, and, in this respect, health care organizations shall comply with the Civil Code.

The owner, unlike persons otherwise entitled to property, may handle his property in an absolute and unconditional manner through his powers to possess, use, and dispose it.

As for health care organizations, they are usually entitled to the right of enjoyment, because most of them have the property in their operational management only. The property lease, however, is the act of disposal.

Subjects to legal relations in leasing include lessors and lessees. Lessor is the party to a lease that owns the property or is a legal representative of the owner.

In respect to government or municipal property, the role of a lessor may be played by either an organization responsible for operational management or business administration of the property, which acts within the scope of delegated authorities, or a specially authorized agency (see Table 1).

Table 1. **Lessors authorized to lease government and municipal property**

Property leased	Lessors
Property in operational management or under business administration of an organization.	1. Organizations may act within the scope of delegated authorities. 2. Specially authorized agencies
Property under business administration of an organization, in force of CC RF, Art.295	1. Organizations may lease realty on owner's consent only. 2. Movable property may be leased w/o owner's consent, unless otherwise is prescribed by laws and regulations.

The right to lease property belongs to the owner. Health care facilities are owned, on the most part, by the federal government and municipalities, and are in operational management of their administrations. Effective legislation delegates the right to lease such property to the Ministry of State Property of the Russian Federation and to persons authorized to lease it either in force of law or by the owner.

Before concluding a contract of lease, it is critical to obtain information about the actual holder of the right of ownership to the property leased.

In this respect, the following situations are typical:

- property in operational management of a health care organization;
- property possessed by an organization;
- property in temporary free use by an organization;
- property rented from other owner;
- property owned by an organization and leased.

Health care organizations may have property in a mixed form of management. If property is in operational management, owner's consent is required to effectuate any deal with it.

In accordance with effective legislation, organizations may not lease or otherwise alienate property procured at the expense of their fixed budgets.

Health care organizations with property in operational management, on having obtained the owner's consent to lease the property, may enter the lease. In such cases, the owner of leased property (Committee on Property Management, the Ministry of Health, or a regional health committee) will sign the lease in the role of lessor, and relevant health care organization will enjoy its right of handling the property in respect to the lease.

Health care organizations are "balance-holders", i.e. corporate persons in charge for technical service, maintenance, exploitation and repair of the leased property. The balance-holder is an administrative representative of the owner. It is not entitled to enter the lease. The lease must be signed by a lessor who is a legal representative of the owner of the property, i.e. relevant title-holding Committee on property management.

As for who and how may handle federal property, a number of regulations exist. For instance, the RF Government Act #96 of 10 February

1994 “On Delegating the RF Government Power to Operate and Handle Federal Property Items”.

By now, a situation has evolved in health sector where health authorities are responsible for implementation of public health programs, and the process of utilization of health care facilities is beyond their scope of competence. Negative consequences of the sinking level of vertical management in health care systems, along with the absence of financial levers to direct bottom-line managers, have resulted in disaggregated health care planning and financing. Those objective trends initiated by the tumult of transition market were further aggravated with the top-to-bottom corruption of health care officials and administrators. Thorough corruption of government executives in charge for public health is but the only explanation behind disadvantageous lease terms from the standpoint of lessor.

In this connection, legislation must be passed to require the consent-obtaining procedure, when it comes to leasing health care facilities, with participation of owner representatives, health care authorities, and the public.

Lessee is a person interested in obtaining the property for its use. In the lessee role, any person subject to civil right may act – either corporate or individual. No specific requirements are imposed by law to such person, as a rule. However, specifics of the social sphere, including health sector, necessitate certain prohibitions and restrictions as for type of activities deployed by lessees with the use of health care facilities’ property. Restrictions should address lessee’s activities associated with moral hazards or incompatible with health care settings, as well as those non-compliant with epidemiological requirements to health care settings.

Idling, temporary and even long enough disuse of property, including workspaces, certain types of facilities (or specialized services within multi-profile health care organization) is not enough grounds to authorize leasing of such property. This applies to capacities intended for use in critical situations, such as epidemic and pandemic occurrences, natural and technologically induced disasters resulting in the upsurge of demand for certain types of medical services. Regional health administration, when planning health network development, must set aside a special reserve of capacities to meet this end.

In accordance with the CC RF, the lessee may not sublease the property of health care organization.

Rights and responsibilities of parties to the lease are determined with the subject of the lease. Lease subjects are property rights, i.e. personal rights of parties to own, enjoy and dispose property, and those real (property-related) requirements that emerge between parties to civil turnover in relation to property distribution and exchange (of commodities, services, currency, equity and so on).

Property may be either fixed or movable. In health sector, immovable items include land lots and everything in tight link to the land, i.e. objects that cannot be removed without causing incommensurate functional damage to them, for instance, buildings and facilities. All items of fixed property may be leased.

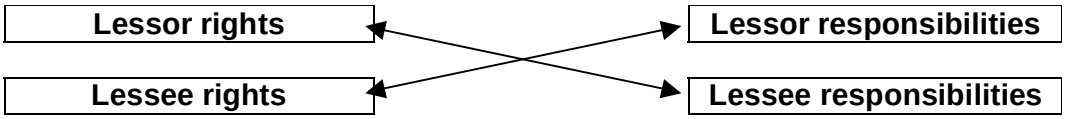
Property items not included in the category of fixed property, including currency and equity, are recognized as movable property.

The legal regime of operations with immovable property items (fixed assets, realty) is dependent on the main purpose of such property objects. The goal is to secure special stability of rights to these property items, i.e. to establish particular order of their handling (determine their legal destination). It is achieved with the instrument of state registration of rights to and deals with items of real property.

Since property is the principal subject of leasing relations and there is no universal definition of the term *property,* any lease contract shall clarify the precise meaning of that term through construing it in definitions section.

Leasing relations are bipartisan, so the general rule applies: rights and responsibilities of the lessor and the lessee must cross-correspond (see Figure 1).

Figure 1. **Achieving the balance of rights and responsibilities of parties to bilateral legal relations in leasing.**



The main regulator of the balance of lessor's and lessee's interests is the rental rate that should be determined through negotiation based on current offer and demand for the type of property being leased.

Effective legislation unequivocally requires that rentals be directed to the government budget, thus annihilating the balancing function of rental.

The obligatory transfer of the entire rent to the government at actual market rental rates, as provided for in present legislation, deprives administrators of health care facilities of any social and economic motivation to enter such leases and pushes them to the "shadow" market. As soon as directors of a health care organization have decided to initiate commercial use of idle property, parties do their best to avoid formalizing the lease and enter an agreement on joint activities. Time to time, no documents at all are signed, and rental fees are appropriated by parties. If after all, in force of objective factors, parties conclude a formal lease, the value of leased property and, as the result, the rental rate indicated therein is usually severely underestimated. After that, the smaller part of rental amount will be channeled to the government budget, and the larger part will stay in the "shadow".

Therefore, the absolute condition for bringing leasing relations in health sector out of "shadow" market is to pass a legislative act that will make health care organizations direct recipients of rentals and protect the planned amount of government allocations to them from any cutbacks in connection to their leasing activities. Concurrently to changing the recipient of rentals paid for the leased property of public health system, a procedure must be adopted for targeted utilization of financial resources generated with leasing. Rental amounts must be used, first, to cover costs of development and maintenance of facilities of health care organization leasing its spare capacities, and second, to support functional integration and availability of the entire municipal health network responsible for delivery of care under state-guaranteed program of free health benefits.

When making decisions about the best use of resources accumulated with rentals, consideration should be given, on one hand, to interests of

balance-holding health care organizations, and on the other hand, to interests of the owner representing general public interest in health system development.

These two groups of interests are contradictory and require efforts to align them in order to attain maximal social effect with the use of resources generated with leasing. The main route to overcome the contradiction is to develop a methodology for structuring rentals at the level of individual lease contract and to accumulate part of them at a separate account disbursed to fund public health needs represented by the owner.

Considering possible methodological approaches to rental distribution, two extremities are present in theory. First option is to channel the entire bulk of rentals to the owner of property to finance targeted programs of territorial health network technical development.

Second option is to leave the total of rentals to a balance-holding health care organization to cover costs of that organization development only.

By now, either of the above options has been put to practice. The first option is partially implemented with effective statutory instruments, and the second was granted to federal health care organizations for an annual term in 1999. In both cases, little social effect was produced with the use of rentals accrued.

Therefore, federal legislators must develop and pass documents to establish the procedure of distribution and centralization of rental fees that will take into account interests of both the owner and the operator of property and align them to social priorities. The structure of rental and the grade of centralization must rely on comprehensive analytic study of status, prospects, location and role of health care organizations in social and economic development of a territory. The final decision about structure of rental and the level of centralization should be left to the owner, as well as the right to accumulate the centralized share of rentals and determine what programs will be funded with it, i.e. to form a reserve for funding targeted programs at the level of executive health authorities – both federal or municipal.

While not doubting the necessity to leave the function of entire rental distribution to the owner, procedures must be in place for public and government oversight of rational utilization of those resources.

For carrying out the function of supervision of rental utilization, it may be helpful to form public coordination boards at municipal administrations, as well as special structures at the Ministry of Health of the Russian Federation and regional health administrations. These public coordination boards and special structures will perform functions of control of centralized rental accrual utilization and review of expenditure effectiveness at federal-level health care organizations. To ensure efficiency of public coordination boards and special structures at executive health authorities, a number of centers for independent review of lease contracts administration in health sector may be established. Along with the above functions, the proposed structures will carry out the function of departmental control of legal aspects of leases.

In implementing functions of control over leasing, certain practical steps have been made already. In particular, with the development of market relations, private property institution, and active operations in realty market, an acute need arose for state registration of ownership rights and transactions with realty. At present, all necessary components are present to create

national-level *legal cadastre* – comprehensive information system including descriptive data on real property items, information about their possessors, their registered real rights and existing injuries (restrictions) of those rights.

Registration of rights to real property and transactions with it is the key element of this legal regime. It is not the end in itself, though, but rather an effective instrument of bringing the market of realty into a civilized state.

An important feature is that registration of ownership rights and transactions in the realty market helps the government to acknowledge and protect these rights.

Registration of transactions bears additional legal meaning and is important for a number of reasons:

1) Registration of leases, along with self-importance, may sometimes play decisive role:

- in determining the precedence of rights to a disputed real property item;
- in prevention of fraud through alienation of property to more than one person, since multiple contracts with the same item will be excluded;

2) Leasing transactions are among widespread grounds giving rise to the right of ownership and the right of lease, as well as other widespread rights to real property.

However, this control is of limited nature, as it excludes evaluation of the social component of leasing property of health care organizations. That is why special controlling bodies need to be instituted.

6. CONCLUSIONS AND PROPOSALS

1. The weakening of government role in managing processes of accrual and utilization of tangible assets in public health sector, along with inadequate funding of state-guaranteed programs of free health benefits, has resulted in significant redundant capacities present at public health care facilities.

As the result, health care organizations face the problem of involving those spare resources into economic turnover in order to improve overall effectiveness of their performance.

2. Adequate laws and regulations are required to effectively return temporarily idle capacities of health care facilities to economic turnover. Effective RF legislation, primarily the Civil Code, that regulate property leasing is inapplicable to health sector in view of unique social status of health care organizations as providers of vital medical services to the population.

In this connection, the pressing need exists in drafting federal-level acts to serve legal basis and economic incentives for improved utilization of health care facilities' property, while protecting public interests.

3. Introduction of leasing in health sector will help align interests of property holder (health care organization) and owner (public).

4. The most promising prospect is to draft a federal act on leasing the property of federal/municipal health care facilities that will have direct action. Such law, if supplemented with thorough regulations and guidelines, will define clear procedures for assessing the worth of health care organizations' property, rating the rental fee, distribution and allocation of revenue generated with the lease, and monitoring of expenditures appropriateness.